(9)

No. 92-7247

In The
SUPREME COURT OF THE UNITED STATES
October Term, 1993

DEE FARMER, *Petitioner*,

v.

EDWARD BRENNAN, WARDEN, *et al.*,
Respondents.

On Writ of Certiorari to the United States
Court of Appeals for the Seventh Circuit

BRIEF FOR D.C. PRISONERS' LEGAL SERVICES PROJECT, INC. AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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November 16, 1993

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QUESTION PRESENTED

Amicus will address the following question:

Should the Court hold that prison officials must act with criminal recklessness in order for their conduct to constitute deliberate indifference under the Eighth Amendment?

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INTEREST OF AMICUS CURIAE[1]

Amicus D.C. Prisoners' Legal Services Project, Inc. ("The Project") is a non-profit organization that provides legal services to prisoners incarcerated by the District of Columbia. The Project currently represents plaintiff inmates in *Inmates of D.C. Jail v. Jackson*, 75-1668 (D.D.C.), an

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[1] Petitioner and respondents have consented to the filing of this brief. Letters are being filed with the Clerk of the Court herewith.

action challenging conditions of confinement in District of Columbia Jail, and is interested in developing the proper legal standard for determining whether prison officials have been deliberately indifferent within the meaning of the Eighth Amendment.

SUMMARY OF ARGUMENT

In *Wilson v. Seiter*, 111 S. Ct. 2321 (1991), this Court held that prison officials must act with "deliberate indifference" in order for cruel prison conditions to violate the Eighth Amendment. The Court held that the deliberate indifference standard should apply to all challenges to conditions of confinement, including claims of inadequate medical care and inadequate protection from other inmates. This case presents the question of the proper interpretation of the deliberate indifference standard, and in particular, whether the Court should hold, as the court of appeals has, that deliberate indifference exists only if prison officials have acted with criminal recklessness.

Although *Wilson* did not detail the elements constituting deliberate indifference, the Court made clear that malice was not one such element. As the criminal recklessness requirement set forth by the court of appeals is tantamount to a requirement of malice, it is in conflict with this part of the holding in *Wilson*. Moreover, by selecting a malice-like standard and thereby permitting relief only in the extraordinary case of official criminality, the court of appeals' ruling unduly narrows the reach of the Eighth Amendment by foreclosing remedies for cruel prison conditions arising from the more common problems of bureaucratic apathy and institutional paralysis.

A criminal recklessness requirement would prove to be poorly suited to remedy the wide range of cruel prison conditions subject to the deliberate indifference standard. Many cruel prison conditions arise from the failure of the institution as a whole, and no one individual bears a share of the blame sufficient to be guilty of criminal recklessness. A pertinent example is the spread of tuberculosis currently facing many prisons. A criminal recklessness requirement would likely send the lower courts on a fruitless search for individual guilt and render them unable to correct grave prison conditions, such as those contributing to the spread of tuberculosis.

In comparison to the criminal recklessness requirement, the obvious, avoidable harm standard set forth in *City of Canton v. Harris*, 489 U.S. 378 (1989), is well suited for challenges to prison conditions under the Eighth Amendment. Under that standard, a plaintiff must show that officials failed to take action to redress a harm that was obvious and avoidable. The *Canton* standard serves to determine when the infliction of harm is attributable to the State as a deliberate choice. Such an analysis satisfies the requirements of *Wilson*. In addition, because the *Canton* standard was developed in the context of municipal (as opposed to individual) liability, it is well suited for determining the "mental state" of institutional entities like prisons.

The court of appeals rejected a *Canton* standard because it found that such a standard would unduly broaden the scope of prison officials' liability. Those fears are unfounded. The requirement under *Canton* that the harm be both obvious and *avoidable* will ensure that prison officials are not held strictly liable as a result of the inherent dangerousness of prisons. Moreover, established doctrines of qualified immunity

already ensure that individual prison officials are not held liable for damages for prison conditions beyond their control.

As the court below applied the wrong standard, the case should be remanded with instructions to reinstate the claim.

ARGUMENT

THE COURT OF APPEALS ERRED IN EQUATING DELIBERATE INDIFFERENCE WITH CRIMINAL RECKLESSNESS.

A. A Criminal Recklessness Requirement Is Contrary To The Decisions Of This Court And To The Proper Scope Of The Eighth Amendment.

In *Wilson v. Seiter*, 111 S. Ct. 2321 (1991), this Court held that prison officials must act with "deliberate indifference" in order for objectively cruel prison conditions to violate the Eighth Amendment. *Id.* at 2326. The requirement of deliberate indifference arose from the Court's conclusion that the infliction of pain does not constitute "punishment" — thereby falling within the purview of the Amendment's prohibition on cruel and unusual punishment — unless the pain is inflicted deliberately, with "some form of intent." *Id.* at 2325. Rejecting a higher "malice standard" proferred by prison officials in that case, the Court determined that deliberate indifference to cruel prison conditions would suffice to elevate those conditions to the level of cruel and unusual punishment. *Id.* at 2326.

In this case, the district court dismissed petitioner's claim because it concluded that petitioner had failed to demonstrate that the respondents had acted with criminal recklessness. In

so doing, the court followed settled circuit law equating *Wilson*'s deliberate indifference standard with criminal recklessness. *See, e.g., McGill v. Duckworth*, 944 F.2d 344, 349-50 (7th Cir. 1991), *cert. denied*, 112 S. Ct. 1265 (1992). This circuit law should be rejected here: the equation of deliberate indifference with criminal recklessness conflicts with *Wilson*'s rejection of a malice standard and improperly limits the reach of the Eighth Amendment.

The court of appeals' criminal recklessness standard is indistinguishable from the malice standard rejected by *Wilson*. For example, in *Duckworth v. Franzen*, 780 F.2d 645 (7th Cir. 1985), *cert. denied*, 479 U.S. 816 (1986), the court instructed that, to act in a criminally reckless manner, an officer must be more than "willful and wanton" — he must be "willful and *malicious*." 780 F.2d at 654 (emphasis added). Similarly, under *McGill*, a prisoner must show that prison officials permitted cruel conditions "*because of*, rather than *in spite of*, the risk to him." *McGill*, 944 F.2d at 350 (emphasis in original).[2]

Such a criminal recklessness standard, as described by the court of appeals, is the same as the malice standard that the Court applied in the prison-riot context. *See Whitley v. Albers*, 475 U.S. 312, 320-21 (1986) ("'whether force was applied in a good faith effort to maintain or restore discipline

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[2] The court in *McGill* held that, in order to succeed on his claim, the prisoner would have to demonstrate that the prison officials knew of the impending rape and could easily have prevented it, but instead stood by and let it happen. *See* 944 F.2d at 349 ("McGill had to show that the defendants had actual knowledge of the threat Ausley posed, that the rape was readily preventable, but that instead of intervening the guards allowed Ausley to proceed."). The court thus clearly equated criminal recklessness with malicious and sadistic conduct.

or maliciously and sadistically *for the very purpose of causing harm.*'") (quoting *Johnson v. Glick*, 481 F.2d 1028, 1033 (2d Cir.), *cert. denied sub nom. John v. Johnson*, 414 U.S. 1033 (1973)) (emphasis added). Indeed, *Whitley* cited the Seventh Circuit's criminal recklessness standard to illustrate the malicious and sadistic standard. *See id.* at 321 (citing *Franzen*, 780 F.2d at 652). But the Court in *Wilson* rejected the *Whitley* standard as inappropriate for use in challenges to prison conditions. *See* 111 S. Ct. at 2326-27.

The court of appeals' error is not in its characterization of the criminal recklessness standard, but rather in its selection of a criminal mental state requirement, especially one as high as criminal recklessness, to begin with. Whether criminal recklessness is equivalent to malice or falls just shy, it unquestionably demands a gross deviation from the conduct of law-abiding persons. *See* MODEL PENAL CODE § 2.02(2)(c). It is a high standard, one sufficient to support a conviction for second-degree murder. *See Franzen*, 780 F.2d at 652.

As a consequence, the criminal recklessness standard at the very least strains the *Wilson* framework. *Wilson* suggests that the necessary mental state to elevate the infliction of pain to the level of "punishment" should vary — ranging from deliberate indifference to malice — depending upon the "constraints" facing the official. *See Wilson*, 111 S. Ct. at 2326. Because criminal recklessness is so near malice, equating it with deliberate indifference severely confines this range.[3]

[3] Indeed, given the strong evidence in *Franzen* and *McGill* that criminal recklessness is malice, one might be tempted to state that the two ends of the range are separated from each other, at the most, by a legal quibble.

Moreover, there seems little warrant in the Eighth Amendment for the adoption of such a severe standard. The Eighth Amendment surely prohibits deplorable prison conditions that arise from bureaucratic apathy or institutionalized indifference as well as those arising from a criminal mindset. *See Rhodes v. Chapman*, 452 U.S. 337, 357, 358-59 (1981) (Brennan, J., concurring) (noting that cruel prison conditions typically arise from insufficient resources, gross managerial inattention, or institutional paralysis). As Judge Noonan has observed:

> The Framers were familiar from their wartime experience of British prisons with the kind of cruel punishment administered by a warden with the mentality of a Captain Bligh. *See* Robert Troup Affidavit (Jan. 17, 1777), in *A Salute To Courage*, at 66 (Dennis P. Ryan, ed. 1979). But they were also familiar with the cruelty that came from bureaucratic indifference to the conditions of confinement. *See* Letter from Robert Morris, George Clymer and George Walton to George Washington (Jan. 7, 1777), in 1 *Correspondence of the American Revolution*, at 324-26 (Jared Sparks, ed. 1853); Letter from Benjamin Lincoln to George Washington (Sept. 25, 1780), 3 *Correspondence of the American Revolution* at 96-98; Troup Affidavit, *supra*, at 67. The Framers understood that cruel and unusual punishment can be administered by the failure of those in charge to give heed to the impact of their actions on those within their care.

Jordan v. Gardner, 986 F.2d 1521, 1544 (9th Cir. 1993) (en

banc) (Noonan, J., concurring).[4] Making criminal conduct the touchstone of "punishment" under the Eighth Amendment thus denies that amendment its vital function: that of prohibiting objectively cruel conditions that result from deliberate official action or inaction. The Eighth Amendment proscribes cruel punishment, not merely evil punishment.

B. The "Failure To Prevent A Known Or Obvious Avoidable Harm" Standard Set Forth In *City of Canton v. Harris* Is Most Consistent With The Eighth Amendment.

In *City of Canton v. Harris*, 489 U.S. 378 (1989), this Court set forth the conditions under which deliberate indifference by government officials to a risk of harm will be deemed to constitute a "deliberate" or "conscious" choice to inflict the harm. *See id.* at 389. Deliberate indifference in this sense will arise either from knowledge of the risk or from sufficient "obviousness" of the risk that knowledge will be imputed. *See id.* at 390 n.10; *see also id.* at 396 (O'Connor, J., concurring in part and dissenting in part) (stating that deliberate indifference will arise from "actual or constructive notice" of the risk). In addition, the failure to heed the known or obvious risk must be "closely related to the ultimate injury." *Id.* at 391. In other words, the risk must not both obvious and avoidable.

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[4] For example, Robert Morris, George Clymer, and George Walton complained to George Washington that "[i]t is probable General Howe may say it is contrary to orders, and not with his knowledge, if our people suffer; but this is not sufficient." Letter from Robert Morris, George Clymer and George Walton to George Washington (Jan. 7, 1777), in 1 *Correspondence of the American Revolution*, at 326.

Canton provides the most appropriate interpretation of deliberate indifference for Eighth Amendment purposes. Because it ensures that the infliction of pain is attributable to the State as a deliberate choice, it satisfies the threshhold "punishment" requirement. In addition, for the reasons set forth below, the *Canton* standard has the flexibility — which a criminal recklessness standard lacks — to be applied in a meaningful away across the entire spectrum of cruel prison conditions to which the deliberate indifference standard applies.

Such breadth of application is important because *Wilson* held that the same deliberate indifference test must be applied to all challenges to prison conditions, whether the condition is lack of medical care, poor food, inadequate clothing, intemperate climate, or a failure to protect the inmate from assaults by other inmates. *See Wilson*, 111 S. Ct. at 2326-27. In addition, *Wilson* held that the same deliberate indifference standard applies whether the challenged condition was experienced by only a single inmate or was applied to all. *See id.* at 2324 n.1. Thus, consistent with *Wilson*, whatever interpretation of deliberate indifference the Court applies to petitioner's failure to protect claim will set the standard for all Eighth Amendment challenges to conditions of confinement.

In comparison to a criminal recklessness standard, the *Canton* standard is a far better tool for addressing two frequently-challenged types of prison conditions: the lack of basic medical care or the routine exposure of inmates to infectious disease. That these conditions can constitute an Eighth Amendment violation is incontrovertible. Because incarcerating a prisoner renders him unable to fend for himself, the Constitution requires the State to provide for his

basic human needs. *See, e.g., Helling v. McKinney*, 113 S. Ct. 2475, 2480 (1993); *DeShaney v. Winnebago County DSS*, 489 U.S. 189, 199-200 (1989). Thus, the Eighth Amendment requires, for example, that prisoners be provided with basic medical care, *see Estelle v. Gamble*, 429 U.S. 97, 103 (1976), and be protected from routine exposure to infectious disease, *see Helling*, 113 S. Ct. at 2480; *Lareau v. Manson*, 651 F.2d 96, 109 (2d Cir. 1981).

The criminal recklessness standard is not well adapted to remedying violations of these obligations. Because the standard focusses on individual guilt, it overlooks prison-wide failures in which the fault is diffused over the institution as a whole. *See McGill*, 944 F.2d at 348-49; *cf.* Sayre, *The Present Signification of* Mens Rea *in the Criminal Law*, *in* HARVARD LEGAL ESSAYS 399, 408 (1934) (stating that the requirement of criminal intent was frequently abandoned "if the character of the offense is such that infraction involves widespread public injury, particularly if the effective administration requires prosecution on so wholesale a scale that individual states of mind cannot be looked into or cannot well be proved"). Lack of medical care or routine exposure to infectious disease typically results from the failure of the institution as a whole, and requiring the courts to search for criminal recklessness on the part of an individual prison official will serve only to stymie attempts at reform. This is true not only because no single individual is likely to bear such a substantial fraction of the guilt, but also because prison officials are likely to be rather resistant and uncooperative to attempts to label them as felons. *Cf. Franzen*, 780 F.2d at 652 (noting seriousness of crimes for which criminal recklessness is the requisite mental state).

The inadequacies of the criminal recklessness standard

become apparent if one attempts to apply the standard in the context of the current epidemic of tuberculosis in prison. Although it is a readily preventable disease, tuberculosis infection in recent years has become rampant in prisons, particularly within urban centers, that have failed to take the necessary measures against the epidemic rise of the disease. *See, e.g., DeGidio v. Pung*, 920 F.2d 525, 529 (8th Cir. 1990) (noting that while the first relevant case of active tuberculosis at the Minnesota Correctional Facility at Stillwater was discovered in 1982, within the next few years almost two hundred inmates became infected). This epidemic accordingly constitutes an important context to test the conditions under which a prison's failure to protect inmates from infectious disease may be remedied by a court.

The tuberculosis epidemic in prison typically results not from the *criminal* agency of prison officials but rather from a bureaucratic apathy preventing effective response. A good example is the District of Columbia Jail, where the spread of tuberculosis is due in part to a failure effectively to screen arriving inmates for tuberculosis.[5] The fault for this failure is diffuse. In part, it arises from the use of an outdated and inaccurate screening procedure. App. at 4A. In addition, the screening procedure is being performed improperly: skin tests are conducted improperly and recorded inaccurately by untrained personnel, possibly at night and in the dark. *Id.* Moreover, the Jail lacks medically effective isolation facilities. *Id.* at 6A. Medical personnel have failed to prescribe

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[5] Appendix A to this brief contains excerpts regarding tuberculosis in the Expert Reports on Medical and Mental Health Services at the District of Columbia Jail filed on September 15, 1993 in the consolidated cases of *Campbell v. McGruder*, 1462-71 (D.D.C.), and *Inmates of D.C. Jail v. Jackson*, 75-1668 (D.D.C.).

and follow up effective treatment for those tubercular inmates who are identified, particularly those stricken with the more recent, multiple-drug-resistant strains, *id.* at 5A-6A. The toll from these failures is unnecessary suffering and death. *See id.* at 6A-16A (reviewing patient histories). Moreover, these conditions remain unaddressed in D.C. despite the availability of more effective measures that have been adopted by similar correctional facilities in Chicago, Los Angeles, and New York City. *Id.* at 5A.

In light of the success of other prisons in stopping or slowing the spread of tuberculosis, conditions in the District of Columbia Jail likely represent a failure to prevent an obvious, avoidable harm under *Canton*.[6] *Cf. DeGidio*, 920 F.2d at 530-33 (analyzing spread of tuberculosis in Minnesota prison). However, because the spread of the disease results from the combined effects of multiple failures at several institutional levels, criminal recklessness on the part of any individual is unlikely to exist or, even if it existed, is unlikely to be found. Despite the obvious, avoidable harm, it is difficult if not impossible to identify any one individual who acted with criminal recklessness. Further, prison officials typically make some effort, albeit inadequate, to screen, isolate, or treat infected inmates, which efforts might well preclude a finding of criminal recklessness. *See id.* at 531 (reporting district court's conclusion that the institutional response to the tuberculosis outbreak, though inadequate, prevented a finding that prison officials "completely abrogated their duties to provide even minimal medical care").

[6] The court in *Campbell v. McGruder*, No. 1462-71, has recently ordered the District of Columbia to institute an effective screening and isolation procedure. *See* App. at 18A-20A; *cf. DeGidio*, 920 F.2d at 588 (affirming the district court's finding that tuberculosis screening in the Minnesota prison improved only as a result of judicial intervention).

By contrast, the *Canton* standard adapts readily to the tuberculosis context. The standard was developed originally to determine municipal liability and accordingly is well-suited to determining deliberateness in a context where knowledge and fault is diffused through institutional layers. *See Canton*, 489 U.S. at 388-89 (discussing difficulties in ascribing deliberateness to corporate entity). In addition, by requiring that the harm be obvious and avoidable the *Canton* standard ensures that the institution has notice of the problem and a fair opportunity to correct it before a constitutional violation will result. *See id.* at 395 (O'Connor, J., concurring in relevant part) (observing that the *Canton* standard ensures "some form of notice . . . and the opportunity to conform to constitutional dictates").

The criminal recklessness standard also fails in the context of infectious disease and lack of medical care because the standard focusses unduly on the immediacy of the harm and the specificity of the threat. For example, in *McGill* a prisoner sought damages arising from his sexual assault by another inmate. The court rejected the claim because the prisoner had failed to demonstrate that officials knew he was about to be attacked by that inmate, *see id.* at 349, and held that it was insufficient as a matter of law to show that officials knew of the more broadly defined risk of harm that assaultive inmates posed to young or vulnerable inmates generally, *see id.* at 350. Thus, to the Seventh Circuit it was irrelevant whether McGill could show that his assailant was known to be highly dangerous and that safety measures could have been readily adopted; no Eighth Amendment violation could result because officials did not know that the assailant would attack McGill instead of some other young and small

victim. *See also Ruefly v. Landon*, 825 F.2d 792, 794 (4th Cir. 1987) (requiring prison officials to be aware that assailant posed specific threat to that particular prisoner).

The *McGill* specific knowledge requirement would have even more dangerous consequences if it were extended to medical care cases. A prison medical staff that fails to respond to medical needs threatens to harm the entire prison population. In such circumstances, a prisoner likely cannot demonstrate the imminent, specific harm to himself necessary to satisfy the criminal recklessness standard. That standard will therefore prevent a court from granting relief to inmates who are threatened with harm but have not yet fallen ill or died.[7] *Cf. Morissette v. United States*, 342 U.S. 246, 256 (1952) (noting that one type of criminal statute for which a *mens rea* requirement has been abandoned is that for which violations "result in no direct or immediate injury to person or property but merely create the danger or probability of it which the law seeks to minimize").

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[7] For this reason, a criminal recklessness standard would be particularly ill-suited to cases in which inmates seek prospective injunctive relief. Because such suits focus on the likelihood of harm in the future, the requirement of knowledge of a specific, imminent harm may be impossible to prove. *See* Siegal, *Rape in Prison and AIDS: A Challenge for the Eighth Amendment Framework of Wilson v. Seiter*, 44 STAN. L. REV. 1541, 1578 n. 270 (1992) ("The Seventh Circuit required actual knowledge of a specific rape — a standard that makes prospective relief nearly impossible to obtain."). This limitation on prospective relief is contrary to a sensible interpretation of the Eighth Amendment. *See Helling*, 113 S. Ct. 2481 ("It would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition in their prison on the ground that nothing yet had happened to them."). Under the *Canton* standard, by contrast, prospective relief would be available if defendants had notice of the cruel conditions and the conditions were avoidable.

A standard that permits routine exposure to infectious disease — merely because one cannot foretell with certainty the precise identity and circumstances of the next victim of a prison-wide danger — does not properly implement the principles of the Eighth Amendment. As this Court observed regarding exposure of inmates to hepatitis and venereal disease, "[t]his was one of the prison conditions for which the Eighth Amendment required a remedy, even though it was not alleged that the likely harm would occur immediately and even though the possible infection might not affect all of those exposed." *Helling*, 113 S. Ct. at 2480.

C. The Reasons Set Forth By The Court of Appeals For Rejecting An Obvious Avoidable Harm Standard Are Unpersuasive.

In *McGill*, the court of appeals expressly rejected an interpretation of deliberate indifference similar to the obvious, avoidable harm standard advanced here. *See* 944 F.2d at 348. The court concluded that this standard would impose too much liability on prison officials. *See, e.g., id.* (criticizing a should have known standard as "approach[ing] absolute liability"). This was so, reasoned the court, because "[p]risons are dangerous places," and therefore "it will *always* be possible to say that the guards 'should have known' of the risk." *Id.* at 345, 348 (emphasis in original). In addition, the court observed that many of the factors that make prisons a dangerous place are beyond the control of prison officials, and therefore the Eighth Amendment should not force prison officials to bear the costs of decisions made elsewhere. *See id.* at 348-49. Both of the court's reasons are meritless: the obvious, avoidable harm standard does not amount to absolute liability and the court's concerns regarding official liability fail to distinguish between the sub-

stantive elements of an Eighth Amendment violation and issues regarding the proper remedy.

The *McGill* court simply erred in concluding that, because prisons are "dangerous places," the *Canton* standard will amount to absolute liability. The court neglected to note that, under *Canton*, the obvious harm must also be *avoidable* in order to give rise to deliberate indifference. In other words, before a failure to respond to an obvious harm will give rise to a violation, the prisoner must demonstrate that the failure to respond is "closely related" to the harm. *Canton*, 489 U.S. at 391. Indeed, the Court in *Canton* expressly recognized that, in contexts where harm is endemic, the requirement of avoidability serves to *forestall* absolute immunity. *Id.* at 391-92 (stating that causation requirement will prevent injuries resulting from constitutional violations by the police from invariably giving rise to municipal liability).

To the extent that "prisons are dangerous places," it is less likely that a given assault is avoidable: If the prisoner complains that the threat of assaults on the general population was obvious, then he must also demonstrate that those assaults could have been avoided generally, a difficult standard to meet. On the other hand, if the prisoner alleges a threat specific to himself, then the *obviousness* standard will clearly be more difficult to satisfy.[8]

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[8] Nor will it necessarily be easy for a plaintiff to prove avoidability in an individual case. While this Court has stated that the question is open whether insufficient resources is a defense to liability, *see Wilson*, 111 S. Ct. at 2326, the Eighth Amendment certainly does not demand that prison resources be infinite. And, of course, a claim for additional resources is likely to be less compelling when the prisoner complains of a danger (continued...)

This sliding scale of obviousness and avoidability, which permits the *Canton* standard to adapt to both general and specific threats, is a direct result of that standard's origin in the concept of "deliberate indifference." A prison official can only be deliberately indifferent to a matter if attention is due that matter. Attention is only due to those matters which are both substantial enough to warrant attention — *i.e.*, obvious — and within the official's power to fix — *i.e.*, avoidable.

The court of appeals in *McGill* was also wrong to reject the *Canton* standard out of a concern that prison officials will be held personally liable for harms beyond their control. As an initial matter, the court of appeals was apparently mistaken in its basic premise; under settled immunity doctrine, prison officials are normally shielded from personal liability for harms beyond their control. *Compare Youngberg v. Romeo*, 457 U.S. 307, 323 (1982) (holding that "[i]n an action for damages against a professional in his individual capacity . . . the professional will not be liable if he was unable to satisfy his normal professional standards because of budgetary constraints") *with McGill*, 944 F.2d at 350 (concluding that a proffered "'should have known' approach" would "hold[] guards personally liable for the consequences of budgetary decisions made elsewhere").

But even putting aside the court of appeals' likely misreading of immunity doctrine, its reasoning is fundamentally misdirected. The court allowed its remedial concerns regarding the scope of official liability for damages to control

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[8] (...continued)
specific to himself rather than one that threatens the entire prison population.

its analysis of the substantive reach of the Eighth Amendment. Such reasoning clearly produces deleterious consequences: seeking to prevent monetary awards, it would also prevent injunctive relief where such relief was clearly warranted.

Even if cruel prison conditions arise from a combination of factors, some of which are external to the prison, government officials may nevertheless exhibit collectively the requisite "deliberate indifference" to those conditions by failing to remedy or ameliorate them. In such case, although any individual official will probably not have made all of the judgments responsible for the cruel conditions, the lawsuit will ensure that those officials who are in a position to improve those conditions are appropriately called upon to answer for them when sued in their official capacity.[9] To paraphrase *Wilson*, cruel prison conditions arising from diffused institutional indifference either constitute "punishment" or they do not; the impact on a prison official's pocketbook is simply irrelevant. *See* 111 S. Ct. at 2326.[10]

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[9] This point has not escaped the court of appeals, which appears to have applied a much less demanding standard in at least some suits including injunctive relief. *See Murphy v. Lane*, 833 F.2d 106, 108 (7th Cir. 1987) (stating that deliberate indifference may be demonstrated by repeated negligent acts or systemic deficiencies); *French v. Owens*, 77 F.2d 1250, 1254 (7th Cir. 1985) (applying repeated negligent acts or systemic deficiencies standard), *cert. denied*, 479 U.S. 817 (1986); *Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983) (determining that repeated acts of negligent medical care constitute deliberate indifference), *cert. denied*, 486 U.S. 1217 (1984).

[10] *Amicus* recognizes that *Wilson* leaves room for "institutional constraints" to affect the level of wantonness necessary to give rise to an Eighth Amendment violation. *See* 111 S. Ct. at 2326. However, concerns (continued...)

* * * * *

The court of appeals incorrectly applied the heightened standard of criminal recklessness to the claim that prison officials were deliberately indifferent to the petitioner's safety. Accordingly, the judgment should be vacated and the case remanded for further consideration under the proper standard. *See Wilson*, 111 S. Ct. at 2328.

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[10] (...continued)
regarding the personal liability of prison officials could only conceivably be such a "constraint" if they were not adequately addressed by doctrines of official immunity. As shown in the text, however, those doctrines are more than adequate to address the concerns raised by the court of appeals.

CONCLUSION

The judgment of the court of appeals should be vacated and the case remanded.

Respectfully submitted.

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APPENDICES

APPENDIX A

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

LEONARD CAMPBELL, *et al.*, Plaintiffs, v. ANDERSON McGRUDER, *et al.*, Defendants.	)	C.A. No. 1462-71 (WBB)
INMATES OF D.C. JAIL, *et al.*, Plaintiffs, v. DELBERT C. JACKSON, *et al.* Defendants.	)	C.A. No. 75-1668 (Cases consolidated before Judge William B. Bryant)

EXPERT REPORTS ON THE MEDICAL AND MENTAL HEALTH SERVICES AT THE DISTRICT OF COLUMBIA JAIL

September 15, 1993

REVIEW OF MEDICAL SERVICES IN THE CENTRAL DETENTION FACILITY (CDF)

Campbell v. McGruder and *Inmates of D.C. Jail v. Jackson*

September 15, 1993

Robert L. Cohen

INTRODUCTION

The following report on medical services at the Central Detention Facility (CDF) was carried out at request of Grace Lopes, Esq., Special Officer for the Court, appointed in the matter of *Campbell v. McGruder* and *Inmates of D.C. Jail v. Jackson*, by U.S. District Judge William B. Bryant. Ms. Lopes requested that I review the medical services at the Jail to see if they are compliant [*sic*] with the Court's requirements, and to review staffing at the CDF.

* * * * *

TUBERCULOSIS

Tuberculosis is a problem in jails in the United States today. Tuberculosis is epidemic in the general society, and it is concentrated in urban jails which concentrate those affiliated with poverty and HIV infection, the two major risk factors for HIV infection.

Screening for tuberculosis has historically been based upon the PPD test, in which a small amount of purified protein from the tuberculosis organism is injected into the skin. Classically, if the person has been infected with tuberculosis there is a swelling at the area of injection and a chest x-ray is then taken to determine if the infection is latent or inactive. If active, the person is isolated and begun on treatment for tuberculosis. If latent, then INH, an anti-tuberculosis medication is usually recommended for chemo-prophylaxis, to prevent the development of tuberculosis in an infected individual without active disease.

There is good documentation of PPD screening at CDF. This is a complicated process, requiring visual inspection of each new prisoner between 48 and 72 hours after implantation of the PPD. I requested staff of the Special Officer to review PPD implantation and reading at CDF. This chart review of PPD screening over the past year provides documentary evidence that PPD reading is occurring at CDF. It must be noted, however, that prisoners claim that PPD reading is being performed by correctional officers in the middle of the night, in the dark, and that staff at Modular say that they have no confidence in PPD readings recorded at CDF and do not feel that actual reading is of the skin test is taking place. Implanting and reading PPD tests is a very labor intensive activity, and requires constant support and monitoring of staff. This function should be performed by the nursing department, by LPN's.

Unfortunately, the PPD test is no longer effective as a screening test for tuberculosis. Persons with HIV infection who have decreased immunity are often **anergic**, which means they do not respond with a positive skin test to organisms they have been previously infected with. Persons with HIV infection and decreased immunity are at substantially higher risk for tuberculosis. If they have active tuberculosis, however, they will not be identified by the PPD test because they are anergic; their PPD test will be negative.

This problem must be addressed. There are two approaches which can be taken. All incoming prisoners can have an admission chest x-ray immediately upon entry into the facility. This should detect all cases of active tuberculosis before there is an opportunity for spread within the facility to other prisoners and Department of Corrections' staff. This approach is currently being used in Chicago and

in Los Angeles and is being gradually adopted in New York City.

Another option is to screen all incoming prisoners for anergy by testing them with PPD as well as other substances (mumps, candida, etc.). If they react positively to the PPD, they get an X-ray; if they don't react to any of the substances they are anergic and they also get an X-ray. The second approach is much more complicated, and more likely to miss cases of active tuberculosis due to misreading of anergy testing.

There is no capacity for admission screening X-rays at the present time at CDF. Routing chest x-rays could be done but would require that the x-ray department stay open 24 hours a day. X-rays can be taken with current equipment or with special equipment designed for mass screening which take x-rays on 70mm film and are read through a special viewer. Although requiring an initial capital outlay, this system is efficient and would have great benefit for the jail as well as the community at large.

In D.C. today, as in other cities throughout the United States, there is a new tuberculosis epidemic of "Multi-drug resistant tuberculosis (MDR-TB)." This disease, which caused 18 deaths in the New York State Department of Correction two years ago, usually affects persons with HIV infection. It is caused by the same tuberculosis bacteria, but the disease responds poorly to the usual anti-tuberculous treatment. It must be diagnosed early, treated aggressively with up to six or seven medications, some of which must be given intravenously. There have been at least two cases of MDR-TB in CDF over the past two years. This disease is transmitted directly from one person to another in crowded

jails, and enhanced efforts to detect it prior to housing prisoners in the general population must be undertaken.

These questions are not abstract. Active tuberculosis is common in the CDF and often goes unrecognized and untreated or is inappropriately treated. I have reviewed documented cases of failure to diagnose and treat tuberculosis at CDF from 1990, 1991, 1992, and extending to the present. There are no adequate isolation facilities for patients with tuberculosis at CDF. A review of some of the recent experience with tuberculosis at CDF will be helpful to illuminate these issues.

Patient #12 -- The patient was admitted to CDF in February 1992. On 2/6/92 her PPD was positive. A chest x-ray was done and reported negative. She was not started on INH. On 6/19/92 she requested sick call, complaining of coughing. Her temperature was not checked and she wasn't examined.

On 6/25/92 she again complained of a cold. No examination took place. On 6/30/92 she complained of chest pain when breathing as well as chills and a headache. No chest X-ray was taken and she was given reflex (an antibiotic). On 7/8/92 she again complained of a cold. On 7/30/92 she complained of a cough. She was not examined and her temperature wasn't taken. Again on 8/2/93 she complained of a cough but wasn't examined.

She was re-admitted to CDF on 11/7/92. At that time her PPD was again noted to be positive but this time the chest x-ray was abnormal, showing infiltrates in the right upper lobe and the right lower lobe. The radiologist advised repeating the film in seven to ten days; this is a completely

inappropriate recommendation. The patient need immediate isolation and workup for tuberculosis. This was fortunately done and the patient was admitted to DCGH on 11/11/92.

She was discharged from DCGH two months later, in January, 1993, and returned to CDF. A positive culture was sent by District of Columbia Department of Public Health (DCDPH) to the CDC (Centers for Disease Control) on 1/1/93 to determine to which antibiotics the tuberculous bacteria were sensitive. The CDC reported back five weeks later, on 2/9/93 that the patient had multi-drug resistant tuberculosis, and that her infection was resistant to the usual medicines, including those she was being treated with: INH, Rifampin, Streptomycin, Ethambutol, and Pyrazinamide. The CEF was not informed of the multi-drug resistance until 3/12/93, although DCDPH own documents reveal that they logged in the sensitivity reports from CDC on 2/16/93. The patient was readmitted to CDGH 3/12/93. She had been at CDF with contagious, multi-drug resistant tuberculosis for at least six weeks following her initial discharge from DCGH, and probably for a significant period of time prior to the November admission.

She was discharged back to the CDF from DCGH on 5/12/93, and admitted to the infirmary. She was discharged on treatment with three drugs: Pyrazinamide, Cipro, and intravenous Kanamycin. Kanamycin is an antibiotic which can only be given by injection. Multiple drugs are given when active tuberculosis is being treated because there is less chance that the bacteria would become resistant to all three drugs at the same time. Failure to provide all the drugs usually results in death, as well as increased spread of MDR-TB.

When I reviewed the patient's infirmary chart on 6/1/93, I noted that she was not receiving kanamycin. I immediately notified the pharmacy staff who were aware that the medicine had been ordered one week before, but said they were unable to obtain it, even though she had been receiving it at DCGH. I also informed Dr. Edwards, the acting Chief Medical Officer, who said he was not aware of the problem. No efforts were made by any physicians, nurses, or pharmacists to obtain this critical medication even though the entire facility medical staff, as well as Mr. Henderson were well aware of this patient's diagnosis.

Patient #13

This patient was well known to Department of Corrections' medical services because of multiple previous admissions. He was admitted for the final time on 11/24/91. He was HIV positive. At that time he complained of a thirty pound weight loss. The history sheet notes that he was being treated for tuberculosis with INH and B6, drugs used for treatment of a positive PPD test, not for active tuberculosis. He had been PPD negative and had not had any history of tuberculosis four months earlier. His T-cells were known to be 96 in April 1991, indicative of severely impaired immune status. The history and physical examination was checked off as "normal" except for missing teeth. A chest X-ray taken on 11/24/91 was read as normal.

On 12/6/91 he was seen in the ID clinic by a physician assistant. No history was taken, no vital signs, no temperature, no weight, and no physical examination was performed of the eyes, the mouth, the abdomen. The note reports the 4/18/91 T-cells as 1344, even though they were actually 94.

The chest was examined and the patient was noted to have bilateral wheezing, but no diagnosis was made, no Chest X-ray was taken, and no treatment was offered.

On 12/8/91 he was brought to the clinic area at CDF as an emergency. He complained of increasing weakness and inability to walk or maintain his balance for a two week period. No examination was performed. No vital signs were taken. The physician assistant transferred him to the "medical step down unit" to be evaluated by a physician. No laboratory examinations were ordered, and no physical examination was performed to identify the extent or cause of his weakens and lack of balance.

He was not seen until the next day, 12/9/91. The physician's note reads: "Patient gives no complaints." No history was taken, no physical examination performed.

On 12/10/91 the physician's note reads "Patient states that he is here for evaluation. T (temperature) 102F. Plan: to DCGH. Trip ticket completed." Again, no history was taken, no physical examination performed.

The next chart note is from December 12, 1991, two days later. {Patient has no consult report from DCGH. Patient sent to DCGH (trip ticket completed) 12/10/91. No history, no physical examination, no temperature taken.

A physician next saw the patient in the step-down unit on 12/13/91. The complete note reads "Patient transferred to Infirmary for more direct nursing care." Again there was no physical examination, no vital signs taken, and no history obtained. No laboratory tests were ordered. He received AZT and Bactrim while in the infirmary, no INH, B6 or

other anti-tuberculosis medication.

The next physician visit was four days later, in the infirmary, on 12/17/91. According to the nursing notes, the patient said "I'm hurting." At this time the patient was noted to have a temperature of 103.6 and was sent for a chest X-ray. No physical examination was performed. The X-ray was abnormal and the patient was sent to DCGH. On admission he was noted to be profoundly anemic, requiring blood transfusion. At DCGH he was diagnosed with active tuberculosis. He was sent back to DC Jail briefly but was returned because there were no infirmary beds. He died at DCGH of resistant pulmonary tuberculosis. According to the DCGH death summary, the patient had been admitted to DCGH previously for active pulmonary tuberculosis.
Comment:

The treatment received by _____ was callous, incompetent, failed to diagnose and treat early a disease which is fatal unless diagnosed early and treated aggressively. This lack of care for an obviously serious medical problem also subjected the entire CDF population, prisoners and staff, to active, drug-resistant tuberculosis. On admission _____ told the medical staff he was being treated for tuberculosis. They failed to follow-up and he wa without effective anti-tuberculosis treatment for over three weeks. The drug he was prescribed (INH) does not treat active tuberculosis, and taking it alone in the presence of active tuberculosis just increases the chance of development of resistant tuberculosis, which is what happened to _____ and caused his death.

_____ complained of weight loss, dizziness, loss of balance, and difficulty walking but none of these complaints

were addressed in any manner during his three weeks at CDF. His dizziness would have been promptly explained had the facility ordered a complete blood count. This should have been done routinely for a patient with AIDS on AZT on entry into the facility.

The lack of care _____ received contributed to his death from tuberculosis, and caused his unnecessary pain and suffering. The failure to examine him and to talk to him resulted in the increased suffering and the exposure of prisoners and staff to resistant pulmonary tuberculosis. The lack of access to medical care in the "Medical step-down unit" and int he infirmary are consistent with my review of medical charts and observation of nursing and physician activity in the infirmary in June, 1993.

Patient #14 -- This patient died from tuberculosis. His treatment at CEDF was incompetent and irresponsible; he was HIV positive and had active tuberculosis, documents on chest x-ray at the facility for a year before he was diagnosed and treatment could be started.

The patient was admitted to CDF on 11/31/89. At that time he told the facility he was HIV positive. No PPD test was done. He weighed 175 pounds.

A history and physical form labeled "In Transit" and dated 2/6/90 fails to note his HIV positive status, as does a clinical history dated 3/11/90; a problem list from this date fails to note his HIV status. His weight was then 160 pounds.

On 3/14/90 he was noted to weight 155 pounds. He came to sick call with a complaint of a cold and was given

aspirin and cold tablets. A chest X-ray was ordered.

On 3/23/90 he returned for follow-up and complained of a continuing non-productive cough. At this time he was noted to have oral thrush, and was given mycelex troches. Although laboratory studies were ordered on 3/14/90 and the results received back on 3/16/90, these results are not mentioned in the chart. They show that the patient had T-cells of 170, and was at high risk for pneumocystis carinii pneumonia, but no prophylaxis was given. This has been standard procedure since at least 1988. The patient was started on AZT.

On 3/26/90 he complained of right sided chest pain which increased with breathing and with coughing. He was given motrin. The notes says "Check on Chest X-ray." He returned to the clinic on 4/2/90 and said he felt better. The X-ray was never checked. In fact, the X-ray was not done until 4/08/90, at which time it was abnormal and showed a left upper lobe infiltrate. The radiologist, Dr. Zellis advised "repeat in 7-10 days." The reason for this recommendation is not clear. Tuberculosis most typically present as an upper lobe infiltrate, and this finding should always prompt the radiologist to recommend that the clinician ascertain if the patient has tuberculosis.

An undated note placed between the 4/12/90 note and a 5/3/90 chart entry records the abnormal chest x-ray, mentions the possibility of tuberculosis and orders sputum for AFB. There is no record that this study was ever performed. The 5/3/90 note does not follow up on this. There are monthly chart entries each of which has no physical examination, no history, and no vital signs, but just refills of the AZT ordered in April. No laboratory testing to look for

the common side effects of AZT were ordered.

Finally, on 9/21/90, a follow-up X-ray, as suggested in April, was ordered. This film was never taken. Blood tests were obtained however, and demonstrated severe anemia, with an hematocrit of 23.7%. Although noted, no action was taken to identify the cause of the anemia (decreased red blood cells) or to correct it. The patient was continued on AZT, the most likely cause of this severe anemia.

During the next several months he had several episodes of blood in his urine. No examination was performed to identify the cause of this finding, which is associated with tuberculosis.

The next blood tests were obtained on 3/7/91. They showed that the patient was even more severely anemic, with a hematocrit of 19.9, a critical level. The patient was admitted to DCGH for transfusion where the diagnosis of tuberculosis was finally made.

He was returned to CDF on 4/7/91 where he was housed on the medical step down unit. Although the discharge medications ordered by DCGH were INH, Rifampin, and PZA, the anti-tuberculosis medications he was given at CEDF were INH and PZA only, an ineffective treatment for pulmonary tuberculosis in a patient with HIV infection. He was then transferred to Lorton where he was continued on only INH and PZA and placed in general population.

On 5/2/91 his first follow-up visit, other than an encounter for constipation, the patient complained of productive cough and fever. The chart notes the 3/7/91 blood test results, and orders a follow-up CBC and chest x-

ray. This X-ray request noted that the patient had active tuberculosis and was on therapy. Dr. Zellis again read the film, compared it with the 3/22/90 x-ray, and noted consolidation in the left upper lobe. He advised "re-ray in 7-10 days to rule out an underlying neoplasm." No action was taken as a result of this abnormal X-ray.

On 6/12/91 the patient came to clinic complaining that he had not been receiving HIV or TB medications for more than a week. His weight was recorded as 124 pounds. Labs obtained 6 weeks earlier, on May 3, 1991, showed the patient was again severely anemic with a hematocrit of 23.4%. The patient was again admitted to DCGH for transfusion. He returned to CDF on 6/17 and was transferred him back to Lorton. The physician's 6/19/91 note includes no physical examination of the patient and reads:

"S: (subjective) This 50 year old male
HIV positive. Had Pneumonia 8
weeks ago. No pneumocystis. Took
AZT, became anemic. Was transfused
in DCGH. Discharged 2 days ago.
Was at Occoquan. Wants to go back.
O: (objective) Alert in NAD (no acute distress)
A: (assessment) HIV Disease
P: (plan) Return to Occoquan
(signature)

There are no further medical chart notes until 8/1/91, when the patient was admitted back to CDF from Howard University Hospital where he had been for 22 days. He was also noted to be severely jaundice with a total bilirubin of 9.4. The patient was discharged back to CDF with active tuberculosis requiring respiratory isolation. He actually had

two July, 1991 admissions to Howard: he signed out after three days and was then readmitted.

The patient was critically ill at that time and was sent back the next day, 8/2/91, to DCGH where he was found to be critically anemic with an hematocrit of 17.3. His chest x-ray showed a cavitary lesion of the left upper lobe, characteristic of active (and very contagious) pulmonary tuberculosis.

He died two weeks later. The death certificate does not mention tuberculosis although this was clearly the cause of death.

Comment: The care received by this patient is shocking. He had active tuberculosis for over a year while in Department of Corrections; custody without diagnosis. X-rays were interpreted inappropriately, not taken when ordered, and ignored when read. Anti-tuberculosis therapy was administered inappropriately if at all. A patient with active pulmonary tuberculosis was discharged into the general population without considering the risk to the population, and the Chief Medical Officer at CDF transferred the patient, just a few days after his discharge from DCGH, to Lorton without examining the patient or being aware that the had active pulmonary tuberculosis.

Additionally, the care received by this patient for his HIV disease was grossly inadequate, incompetent, and he was continually subjected to unnecessary suffering. He had untreated anemia exacerbated by continuing his AZT without monitoring and without treatment of his anemia. He never received PCP prophylaxis. He was almost never examined and he wasted away in front of the medical staff secondary

to treatable disease.

RECOMMENDATIONS:

1. A system for effective TB screening must be put in place immediately. In the short run, a system of PPD and anergy testing of all incoming prisoners must be implemented. In the long run it is probably wise to develop the capacity to X-ray all new admissions. Additional nursing staff, preferably LPN's, will need to be hired to assure that this screening program is effective.

2. Protocols for diagnosing and treating patients with TB and active disease must be developed. Sputum induction performed in a safe isolation booth (a technique for obtaining sputum for microscopic examination and culture) should be available for patients with mildly abnormal chest x-ray's who are anergic or have positive PPD tests.

3. Tuberculosis medications must be provided and should be distributed to patients under direct observation. The procedures developed in the pharmacy for obtaining medications in emergencies must include those for obtaining the medications used in treating drug resistant tuberculosis.

4. Inmates should be questioned on admission about past history of tuberculosis and the jail should work out a cooperative system with the DCDPH tuberculosis registry for identifying inmates with known disease as well as those who

are PPD positive. There is probably a need for a full time public health worker from DCDPH at the CDF to maintain and update the registry, as well as support other activities regarding public health matters, particularly syphilis.

5. Patients with contagious tuberculosis should be kept in appropriate isolation facilities; these do not currently exist at CDF and must be constructed at this or another facility. Until safe isolation areas have been identified and tested, patients with active tuberculosis must not be housed at CDF.

6. At least six CME lectures should be given annually for all medical staff regarding the diagnosis and treatment of tuberculosis.

7. Screening by X-ray or anergy should be accomplished at least annually for all Department of Corrections' staff, all contract workers at CEF, as well as for all long term prisoners.

8. Radiology services must be enhanced to provide x-rays within 24 hours for persons with positive PPD's or anergy. Radiology reports should aid in the rapid diagnosis of tuberculosis.

APPENDIX B

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

LEONARD CAMPBELL, *et al.*,	)	
	)	C.A. No. 1462-71
Plaintiffs,	)	(WBB)
	)	
v.	)	
	)	
ANDERSON McGRUDER, *et al.*,	)	
	)	
Defendants.	)	
	)	
INMATES OF D.C. JAIL, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	C.A. No. 75-1668
	)	(WBB)
DELBERT C. JACKSON, *et al.*	)	
	)	
Defendants.	)	

ORDER

Upon consideration of the Plaintiffs' Motion for Interim Relief, defendants' opposition thereto, the Special Officer's

Recommendations concerning Interim Relief, the Expert Reports on Medical and Mental Health Services at the District of Columbia Jail, and the record in this case, it is hereby

ORDERED that the plaintiffs' motion is granted; and it is

FURTHER ORDERED that within five days of the date of this Order, unless otherwise provided:

* * * * *

(12) The defendants shall chest x-ray or anergy test every prisoner on intake to the facility and promptly identify any prisoner suspected of suffering from infectious tuberculosis. The defendants shall, in consultation with the Special Officer and her medical expert, develop and implement, within two weeks of the date of this Order, a protocol identifying who shall receive chest x-rays and the procedure for tuberculosis screening on intake to the facility. Plaintiffs' counsel shall have an opportunity to review and comment on the protocol before it is finalized.

(13) The defendants shall identify appropriately equipped isolation rooms for persons with infectious tuberculosis and insure that all infectious cases are isolated.

* * * * *

So ORDERED this 9th day of November, 1993.

[signature]

William B. Bryant
Senior United States District Judge